



1907-001	\$400
1907-006	\$ 10
TOTAL	\$410

**STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TN 37243
www.tennessee.gov**

**TENNESSEE BOARD OF OSTEOPATHIC EXAMINATION
(800) 778-4123, ext. 24384 or (615) 532-3202, ext. 24384
APPLICATION FOR A TELEMEDICINE LICENSE**

ATTACH THE FOLLOWING TO THIS APPLICATION AND MAIL TO:

**Tennessee Board of Osteopathic Examination
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243**

1. A check or money order for Four Hundred Ten Dollars (\$410) payable to the Tennessee Board of Osteopathic Examination.
2. A clear, recognizable, recently taken, photograph that shows the full head (face forward from at least the shoulders up).
3. A notarized copy of a specialty certification from a recognized specialty or a letter from your training program director, which states that you are eligible to apply for the certification examination.
4. Proof of citizenship in the United States or Canada, or evidence of being entitled to live and work in the United States. (Notarized copies of birth certificates, naturalization papers, voter registration, current H-1 Visa status, or current U.S. passports are acceptable.)
5. The completed profile questionnaire pages 1 through 6.

Applicant's Name: _____
(First) (Middle and/or Maiden) (Last)

Date of Birth: _____ Social Security Number: _____
(Month) (Day) (Year) - -

Present Mailing Address: _____

Present Practice Address: _____

Home Phone: () -
Work Phone: () -

Specialty in which certified or eligible: _____

List below all states, countries or provinces in which you have ever been or are currently licensed as an osteopathic doctor. Additional pages may be added if necessary. A Clearance Form (See Attachment) must be received from each state listed.

STATE	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

You must identify a Tennessee licensed physician residing in Tennessee who has agreed to accept service of process from the State if it is unable to personally serve you should the necessity arise. Identify that physician below:

Name: _____ Business Telephone: _____
 Business Address: _____

For the purposes of the competency questions on the pages 3 and 4 of this application, these phrases or words have the following meanings:

1. **“Ability to practice medicine”** is to be construed to include all of the following:
 - a. The cognitive capacity to make appropriate clinical diagnosis, exercise reasoned medical judgments, to learn, and keep abreast of medical developments;
 - b. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
 - c. The physical capability to perform medical tasks such as physical examinations and surgical procedures, with or without the use of aids or devices such as corrective lenses or hearing aids.
2. **“Medical Condition”** includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV, tuberculosis, drug addiction, and alcoholism.

3. **“Chemical substances”** is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber’s direction, as well as those used illegally.
4. **“Currently”** does not mean on the day of or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one’s functioning as a licensee or within the past two (2) years.
5. **“Illegal use of controlled substances”** means the use of controlled substances obtained illegally (e.g. heroin, or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed health care practitioner. You may wish to consult your attorney regarding answers to questions containing this phrase concerning Fifth Amendment (self-incrimination) constitutional protections that might be available to you.

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any questions in this part are in the affirmative, attach an explanation on a separate sheet. In support of your explanation, the final documents or orders from the issuing states, courts, and/or agencies, where appropriate, must be submitted along with the application.

QUESTIONS:

YES

NO

1. Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?

a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program?

b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?

[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.]

2. Do you currently use chemical substances?

If yes, do they in any way impair or limit your ability to practice medicine with reasonable skill and safety?

QUESTIONS CONTINUED:

	YES	NO
3. Are you currently engaged in the illegal use of controlled substances?	_____	_____
If yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances?	_____	_____
4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism?	_____	_____
5. If you have ever held or applied for a license or certificate to practice medicine in any state, country, or province, has or was it ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____
6. If you have ever had staff privileges at any hospital or health care facility have they ever been revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	_____	_____
7. Have you ever applied for and been denied a state or federal controlled substance certificate?	_____	_____
8. Have you ever been convicted of a felony or a misdemeanor other than a minor traffic offense?	_____	_____
9. Have you ever been rejected or censured by a medical society?	_____	_____
10. In relation to the performance of your professional services in any profession:		
a. Have you ever had a final judgment rendered <u>against</u> you;	_____	_____
b. Have you ever had settlement of any legal action rendered <u>against</u> you; or	_____	_____
c. Are there any legal actions pending <u>against</u> you or to which you are a party?	_____	_____
11. If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____

AFFIDAVIT AND RELEASE

I, _____, D.O.,
(Applicant's Name)

_____ being duly
(City) (State)

sworn and identified as the person referred to in this application, attests to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations, which were enclosed in the application packet, and agree to abide by them in the practice of medicine in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview.

AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.

RELEASE from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, or other qualifications for licensure.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, other qualifications, and for resolving any doubts about such qualifications.

AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNATURE

DATE

Sworn to before me this _____ day of _____.

NOTARY PUBLIC

Affix Seal Here

My Commission expires: _____



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TN 37243

TENNESSEE BOARD OF OSTEOPATHIC EXAMINATION
(800) 778-4123, ext. 24384 or (615) 532-3202, ext. 24384
CLEARANCE FROM OTHER STATE LICENSURE BOARDS

APPLICANT: Please provide the information requested in the top box and then mail one (1) form to the Licensure Board in EACH state where you hold OR HAVE EVER HELD a license to practice any profession. (Copies of this form can be used.)

NOTE: Some states require a fee for providing clearance information. To expedite your application, you may wish to contact the applicable state(s).

<p>_____ was granted a license to practice _____ <i>(Name of Applicant)</i> <i>(Profession)</i> with license number _____ on _____ in the State of _____. <i>(Date)</i></p> <p>The Board of Osteopathic Examination of Tennessee requests that I submit evidence of the current status of that license in your state. You are hereby authorized to release any information in your files, favorable or otherwise, directly to:</p> <p>Tennessee Board of Osteopathic Examination 227 French Landing, Suite 300 Heritage Place Metro Center Nashville, TN 37243</p>	<p>_____</p> <p style="text-align: center;">Applicant's Signature</p> <p>_____</p> <p style="text-align: center;">Applicant's typed or printed name</p>
<p>_____</p> <p style="text-align: center;">Date</p>	

ADMINISTRATIVE OFFICE OF STATE LICENSURE BOARD, PLEASE COMPLETE:		
Name In Full As It Appears On License: _____		
License Number: _____	Profession: _____	Date Issued: _____
Basis of issuance: _____ (Check One)	Endorsement/Reciprocity with: _____ (State)	
_____	Written Examination: _____ (Name of Exam)	
The License is currently active and registered?		
	YES _____ NO _____	
Is there any derogatory information on file?		
	YES _____ NO _____	If yes, an explanation must be attached.
_____	_____	_____
Authorized Signature	Title	Date

G4030180



TENNESSEE DEPARTMENT OF
HEALTH

MANDATORY
PRACTITIONER
PROFILE QUESTIONNAIRE

**PURSUANT TO TENNESSEE CODE ANNOTATED SECTION 63-51-101 et seq.,
LAWS OF TENNESSEE**

FOR
LICENSED HEALTH CARE PROVIDERS

FOREWORD

The Health Care Consumer Right-to-Know Act of 1998, T.C.A. § 63-51-101 et seq, requires designated licensed health professionals to furnish certain information to the Tennessee Department of Health. The information specified in the law is contained in the attached questionnaire. From the information submitted, the Department will compile a practitioner profile which is required to be made available to the public via the World Wide Web and toll-free telephone line after May 1, 1999. Each practitioner who has submitted information must update that information in writing by notifying the Department of Health, Healthcare Provider Information Unit, within 30 days after the occurrence of an event or an attainment of a status that is required to be reported by the law. A copy of your initial or updated profile will be furnished to you for your review prior to publication. That opportunity will allow you to make corrections, additions and helpful explanatory comments. Failure to comply with the requirement to submit and update profiling information constitutes a ground for disciplinary action against your license. A blank copy of the profile may be obtained from the following web site address: <http://tennessee.gov/health>.

On the department's homepage, under Licensing, click on "Health Professional Boards"; then select the appropriate board.

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SECTION I: GENERAL INSTRUCTIONS

- ▶ **Read all instructions thoroughly before completing the profile questionnaire. Incomplete or omitted information may delay meeting the mandatory reporting requirement.**
- ▶ **Incomplete or illegible profiles will be returned to the provider for resubmission.**
- ▶ **Some questions do not apply to every profession. If a question does not apply to you, indicate so by checking the “Does not apply” box.**
- ▶ **Provide only information for the previous ten (10) years where indicated on the questionnaire.**
- ▶ **Complete the questionnaire and attachments by typing or printing your response in block letters in ballpoint pen. Incomplete or illegible profiles will be returned to the provider for resubmission. Some questions do not apply to every profession. If a question does not apply to you, indicate so by checking the “Does not apply” box.**
- ▶ **DO NOT RETURN THESE INSTRUCTIONS WITH THE QUESTIONNAIRE TO THE DEPARTMENT.**
- ▶ **You may have completed a similar questionnaire for another state’s licensing board. If so, Tennessee law still requires you to complete and submit this form.**
- ▶ **If you have an active Tennessee license you are required to complete the questionnaire. This includes those practitioners who are retired or no longer practicing.**

- ▶ **Mail the completed ORIGINAL profile questionnaire within thirty (30) days of its receipt by the provider to:**

**Healthcare Provider Information Manager
Tennessee Department of Health
Division of Health Related Boards
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243
1-800-778-4123
Local - (615) 532-3202**

- ▶ **Keep a copy of the questionnaire for your records.**

✓CHECKLIST

Before you mail your questionnaire:

- ☐ Have all questionnaire and supplemental pages been completed with the name of the practitioner, profession and license number at the top of the page?
- ☐ Have supplemental pages been clearly labeled with the corresponding question for which the response is being provided?
- ☐ Have you retained a copy of your signed questionnaire?

SECTION II:

COMPLETING THE PROFILE QUESTIONNAIRE

QUESTIONNAIRE DEADLINE

The provider must submit the questionnaire on or before thirty (30) days from its receipt.

COMPLETING THE FORMS

Complete all forms by printing neatly in block letters in ballpoint pen or typing the information. If a question does not apply to you, indicate so by checking the “Does not apply” box. **Illegible questionnaires will be returned.**

The following numbered parts correspond to the matching number on the questionnaire form.

I. PRACTITIONER DATA

Complete part one (1) noting the following:

- License number: Fill in your license number and indicate your profession in the space provided.
- Social security number: **Your social security number will not be published or in any way given out to the public. It is required for in-house tracking purposes only.**
- Address: Complete mailing and practice address (if applicable). Retirees: Write in “N/A” for practice address.

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

List chronologically all medical/health professional related graduate/postgraduate education and training completed. Exclude any program or courses taken to satisfy continuing education requirements for licensure renewal. Provide information about health related degrees you have received including your licensure degree.

III. SPECIALTY BOARD CERTIFICATIONS

Provide information on any certification, specialty or subspecialty from any specialty board recognized by the American Medical Association, American Osteopathic Medical Association, American Podiatry Association, American Chiropractic Association, American Dental Association or any other specialty certifying body as determined by your Tennessee licensing board.

IV. FACULTY APPOINTMENTS

Answer ALL yes/no questions with a “yes” or “no” response. A brief statement in the space provided should follow a “yes” answer. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

V. STAFF PRIVILEGES

List all hospitals at which you hold staff privileges. This includes:

- Licensed hospitals-this term is defined at T.C.A. § 68-11-201.

In the spaces provided, answer information about the TennCare plans in which you participate, if any. If there are more than five (5), please send attachment.

VI. FINAL DISCIPLINARY ACTION

These questions refer to final disciplinary or adverse actions taken within the previous **ten (10) years**, whether in this state or any other jurisdiction. The term **final** means the matter was fully adjudicated at a hearing and the appeal’s period expired, or that the applicable board issued an agreed order or consent decree.

In the “Description of Violation” spaces, indicate the nature of the conduct in question such as malpractice, unethical conduct, drug-related, sex related, impairment, fraud, etc.

In the “Description of Action” spaces, indicate the type of disciplinary action imposed against your professional license.

The term **disciplinary action** includes, but is not limited to:

- Probation
- Limitation/Restriction
- Suspension
- Revocation
- Voluntary relinquishment in lieu of disciplinary action
- Any other adverse action taken against a license or privilege by a medical/health related institution
- Compulsory surrender of license or privilege
- Civil or other monetary fine or penalty
- Resignation from or non-renewal of medical staff membership at a hospital in lieu of, or in settlement of, a pending disciplinary case related to competence or character
- Restriction of privileges in lieu of, or in settlement of, a pending disciplinary case related to competence or character

If you answer “yes” to any of the questions in this section and if the action is under appeal, you must attach a copy of the notice of appeal. Note: You must submit a copy of the final written order of

disposition immediately after the appeal is disposed of by the adjudicating authority. Please read questions VII B and C in their entirety before answering those questions.

VII. CRIMINAL OFFENSES

This part requires you to report any state or federal felony criminal offense convictions. It also requires the reporting of misdemeanor offenses, regardless of classification, in which any element of the offense involves sex; alcohol or drugs; physical injury or threat of injury to any person; abuse or neglect of any minor, spouse or the elderly; fraud or theft in Tennessee or another jurisdiction; or unlicensed practice of a profession within the most recent ten (10) years. If you answer “yes” to this question and the offense is under appeal, you must submit a copy of the notice of appeal of that criminal offense. Immediately upon disposition of the appeal, you must submit a copy of the final written order of disposition. If any misdemeanor conviction reported is expunged, a copy of the order of expungement signed by the judge must be submitted to the Department before the conviction will be removed from any profile.

VIII. LIABILITY CLAIMS

This section requires you to indicate all medical malpractice court judgments, arbitration awards, or settlements in which a payment was awarded to a complaining party beginning with judgments or settlements entered or executed after May 19, 1998. That means if the act or event leading to the claim occurred in, for instance, 1995, but was finally adjudicated against you after May 19, 1998, you must indicate that claim in the space provided. JUDGMENTS OR SETTLEMENTS BELOW THE THRESHOLD AMOUNT ESTABLISHED BY YOUR TENNESSEE LICENSING BOARD ARE NOT REQUIRED TO BE SUBMITTED. To find out the threshold amount established by your board, consult your board’s web page at www.state.tn.us/health/ or call 1-800-778-4123. Pending malpractice claims are not required to be reported unless/until final adjudication against you.

IX. OPTIONAL INFORMATION

This section is voluntary. You may list, briefly describe, and submit any information/documentation regarding your professional practice in the spaces provided. Attach an additional sheet labeled with the question number if additional space is required.

Practitioner's Name _____ License # _____
Profession _____

SECTION III:

**HEALTHCARE PROVIDER INFORMATION MANAGER
TENNESSEE DEPARTMENT OF HEALTH
DIVISION OF HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TENNESSEE 37243**

I. PRACTITIONER DATA

- A. PROFESSIONAL LICENSE NUMBER: _____ PROFESSION: _____
B. SOCIAL SECURITY NUMBER: _____ (This will not be published as part of the profile or website).

- C. NAME (INCLUDE MAIDEN AND ON 2ND/3RD LINES ANY ALIASES, IF APPLICABLE):
CURRENT NAME:

(LAST) (FIRST) (MIDDLE AND MAIDEN NAME)
(IF APPLICABLE)

FORMER NAME(S):

(LAST) (FIRST) (MIDDLE)

(LAST) (FIRST) (MIDDLE)

- D. MAILING
ADDRESS:

(STREET AND NUMBER)

(CITY) (STATE) (ZIP CODE)

PRIMARY PRACTICE ADDRESS: (This will be published as part of the profile and the web site).

(PRACTICE NAME)

(STREET AND NUMBER)

(CITY) (STATE) (ZIP CODE)

- E. TELEPHONE: (_____) _____ (This will not be published as part of the profile or the web site).

- F. LANGUAGES, OTHER THAN ENGLISH: Indicate languages other than English or translation services that may be available at your primary practice location.

1. _____
2. _____

- G. SUPERVISING PHYSICIAN: If you are required by law to be supervised by a physician (physician assistant or nurse practitioner) indicate the name(s) and address(es) of each supervising physician. If you need more space, attach additional sheets:

1. _____
2. _____

Practitioner's Name _____ License # _____
 Profession _____

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

- A. What school(s)/educational programs have you attended? And, what type(s) of degree(s) do you hold? Do not include coursework taken to meet the continuing education requirement for licensure renewal. (Authority: T.C.A. §63-51-105(a)(6) and (7))

PROGRAM/INSTITUTION	CITY/STATE/ COUNTRY	DATE OF GRADUATION	TYPE OF DEGREE
1.			
2.			
3.			
4.			
5.			
6.			

- B. List in chronological order from date of graduation to the present, all completed medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program). Do not include coursework taken to meet continuing education requirements for licensure renewal. (Authority: T.C.A. § 63-51-105(a)(6))

PROGRAM AND SPECIALTY AREA (INTERNSHIP, RESIDENCY, FELLOWSHIP, ETC.)	LOCATION OF TRAINING (CITY, STATE, COUNTRY)	FROM MM/DD/YYYY	TO MM/DD/YYYY
1.			
2.			
3.			
4.			

Practitioner's Name _____ License # _____
Profession _____

III. SPECIALTY BOARD CERTIFICATIONS

Do you hold a certification, specialty or subspecialty from any specialty board recognized by the board regulating the profession for which you are licensed? (see instructions) (Authority: T.C.A. § 63-51-105(a)(8)) If "Yes", complete section below. YES ☐ NO ☐

CERTIFYING BODY/BOARD INSTITUTION	CERTIFICATION/SPECIALTY/SUBSPECIALTY
1.	
2.	
3.	
4.	
5.	

IV. FACULTY APPOINTMENTS

A. Have you had the responsibility for graduate medical education within the last ten (10) years? (Authority: T.C.A. § 63-51-105(a)(10)) YES ☐ NO ☐

B. Do you currently hold a faculty appointment at a medical/health related institution of higher learning? (Authority: T.C.A. § 63-51-105(a)(10)) YES ☐ NO ☐

If "YES", list the title of the appointment and name(s) and city/state of institution(s). (Attach additional sheets, clearly labeled with this question number, if necessary.)

	TITLE	INSTITUTION	CITY/STATE
1.			
2.			
3.			
4.			

V. STAFF PRIVILEGES

A. Do you currently hold staff privileges at a hospital? (Authority: T.C.A. §63-51-105(a)(a)) YES ☐ NO ☐

If "YES", list each hospital at which you currently have staff privileges: (Attach additional sheets, clearly labeled with this question number, if necessary)

Name of Hospital	City/State
1.	
2.	
3.	
4.	
5.	

Practitioner's Name _____ License # _____
Profession _____

B. Do you currently participate in any TennCare plan? (Authority: T.C.A. § 63-51-105(a)(16)) YES ☐ NO ☐
If "YES", list each plan in which you currently participate:

Name of TennCare Plan

1. _____
2. _____
3. _____
4. _____
5. _____

VI. FINAL DISCIPLINARY ACTION (See Instructions)

A. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by the agency regulating your license, in this state or any other jurisdiction? (Authority: T.C.A. § 63-51-105(a)(8)) YES ☐ NO ☐

If "YES", list name(s) and address(es) of agency(s) and a brief description of the final disciplinary action(s) and stated reason(s) for taking the action. (Attach additional sheets, clearly labeled with this question number, if necessary.)

AGENCY NAME

DATE

DESCRIPTION OF
VIOLATION

DESCRIPTION OF
ACTION

1. _____

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal)

YES ☐ NO ☐

2. _____

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal)

YES ☐ NO ☐

3. _____

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal)

YES ☐ NO ☐

Practitioner's Name _____ License # _____
Profession _____

B. Within the previous ten (10) years, have you ever had your hospital privileges revoked or involuntarily restricted for reasons related to competence or character by the hospital's governing body? (Authority: T.C.A. § 63-15-105(a)(4)) YES ☐ NO ☐

If "YES", list name(s) and address(es) medical institution(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.	_____	_____	_____	_____
	_____		_____	_____
	_____		_____	_____

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ☐ NO ☐

2.	_____	_____	_____	_____
	_____		_____	_____
	_____		_____	_____

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ☐ NO ☐

3.	_____	_____	_____	_____
	_____		_____	_____
	_____		_____	_____

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ☐ NO ☐

C. Within the previous ten (10) years, have you ever been asked to or allowed to resign from or had any medical staff privileges restricted or not renewed by any hospital in lieu of or in settlement of a pending disciplinary action related to competence or character? (Authority: T.C.A. § 63-51-105(a)(4)) YES ☐ NO ☐

If "YES", list name(s) and address(es) of the hospital(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME	DATE	DESCRIPTION OF ACTION
1.	_____	_____	_____
	_____		_____
	_____		_____

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ☐ NO ☐

2.	_____	_____	_____
	_____		_____
	_____		_____

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ☐ NO ☐

3.	_____	_____	_____
	_____		_____
	_____		_____

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ☐ NO ☐

Practitioner's Name _____ License# _____
Profession _____

VII. CRIMINAL OFFENSES (See Instructions)

Have you within the most recent ten (10) years, been found guilty, regardless of whether adjudication of guilt was withheld, or pled guilty or nolo contendere to a criminal misdemeanor or felony in any jurisdiction? (Authority: T.C.A. § 63-15-105(a)(1))

If "YES" briefly describe the offense(s):

YES ☐ NO ☐

DESCRIPTION OF OFFENSE	DATE	JURISDICTION
1. _____ If "YES", is this conviction under appeal? (attach copy of notice of appeal)	_____	YES <input type="checkbox"/> NO <input type="checkbox"/>
2. _____ If "YES", is this conviction under appeal? (attach copy of notice of appeal)	_____	YES <input type="checkbox"/> NO <input type="checkbox"/>
3. _____ If "YES", is this conviction under appeal? (attach copy of notice of appeal)	_____	YES <input type="checkbox"/> NO <input type="checkbox"/>

VIII. LIABILITY CLAIMS

Have you had a medical malpractice court judgment, arbitration award, or settlement against you since May 19, 1998? (Authority: T.C.A. § 63-51-105(a)(5)) If "YES", indicate the date of claim(s) and the amount of judgment(s), award(s) or settlement(s).

ENTRY DATE OF DISPOSITION ORDER OR SETTLEMENT	AMOUNT
1. _____	_____
2. _____	_____
3. _____	_____

IX. OPTIONAL INFORMATION

A. PUBLICATIONS: List any publications you have authored in peer-reviewed medical literature: (optional) (Authority: T.C.A. § 63-15-105(a)(11))

TITLE	PUBLICATION	DATE
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

B. PROFESSIONAL OR COMMUNITY SERVICE ACTIVITIES AWARDS: List any information regarding professional or community service associates, activities and awards: (optional) (Authority: T.C.A. § 63-15-105(a)(12))

COMMUNITY SERVICE/AWARD/HONOR	ORGANIZATION
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

I affirm these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to T.C.A. § 63-51-113 and/or 63-51-118.

(Signature of Provider)
YB/G6019027/RTK-ms.70

Date: _____